Center for Oral Health Systems Integration and Improvement

Oral Health Quality Indicators for the Maternal and Child Health Population: Technical Specifications and User Guide for 2019 Reporting

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Prepared by:

Dental Quality Alliance

National Maternal and Child Oral Health Resource Center

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Table of Contents

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Indicator Sources

Indicators Derived from Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. www.cdc.gov/brfss

Indicators Derived from Centers for Disease Control and Prevention Pregnancy Risk Assessment Monitoring System

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Pregnancy Risk Assessment Monitory System. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. www.cdc.gov/prams

Indicators Derived from Association of State and Territorial Dental Directors Basic Screening Survey

Association of State and Territorial Dental Directors. 2015. *ASTDD Basic Screening Survey for Children Planning and Implementation Tool.* Reno, NV: Association of State and Territorial Dental Directors. www.astdd.org/basic-screening-survey-tool

Dental Quality Alliance Measures

Dental Quality Alliance Measures (Measures) and related data specifications, developed by the Dental Quality Alliance (DQA), are intended to facilitate quality improvement activities. These Measures are intended to assist stakeholders in enhancing quality of care. These performance Measures are not clinical guidelines and do not establish a standard of care. The DQA has not tested its Measures for all potential applications.

Measures are subject to review and may be revised or rescinded at any time by the DQA. The Measures may not be altered without the prior written approval of the DQA. Measures developed by the DQA, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and DQA. Neither the DQA nor its members shall be responsible for any use of these Measures.

THE Measures are provided "as is" without warranty of any kind.

Limited proprietary coding is contained in the measure specifications for convenience.

Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The DQA, American Dental Association (ADA), and its members disclaim all liability for use or accuracy of any terminologies or other coding contained in the specifications.

Proprietary Codes

Technical Assistance and Contacts

Technical assistance is available to state implementation teams on the collection, analysis, and interpretation of oral health quality indicator data.

Contact Marissa Sanders, sandersm@ada.org, to be connected to the appropriate technical advisor.

Online Resources

Association of State and Territorial Dental Directors, www.astdd.org

- ASTDD Basic Screening Surveys, www.astdd.org/basic-screening-survey-tool

Centers for Disease Control and Prevention, www.cdc.gov

- Behavioral Risk Factor Surveillance System (BRFSS), www.cdc.gov/brfss
    - The BRFSS Data User Guide, www.cdc.gov/brfss/data_documentation/pdf/UserguideJune2013.pdf
- Pregnancy Risk Assessment Monitoring System (PRAMS), www.cdc.gov/prams/index.htm
    - Participating PRAMS Sites, www.cdc.gov/prams/states.htm

Centers for Medicare & Medicaid Services, www.medicaid.gov

- Children's Health Insurance Program (CHIP), www.medicaid.gov/chip/index.html
- Dental Care, www.medicaid.gov/medicaid/benefits/dental/index.html
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), www.medicaid.gov/medicaid/benefits/epsdt/index.html
- Expenditure Reports from MBES/CBES, www.medicaid.gov/medicaid/finance/state-expenditure-reporting/expenditure-reports/index.html [Provides Medicaid and CHIP spending on dental services, along with other services and administrative expenses.]
- Learn How to Report the CMS 416 Dental Data, www.medicaid.gov/medicaid/benefits/prevention/416-dental-reporting-training.html

Agency for Healthcare Research and Quality, www.ahrq.gov

- Consumer Assessment of Healthcare Providers and Systems, www.ahrq.gov/cahps/index.html

Dental Quality Alliance, www.ada.org/dqa

- Educational Resources, www.ada.org/en/science-research/dental-quality-alliance/dqa_educational_resources
- Program/Plan Level Dental Quality Measures, www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-development-reports/dqa-dental-quality-measures

Maternal and Child Health Bureau, mchb.hrsa.gov

- Federally Available Data (FAD) Resource Document, mchb.tvisdata.hrsa.gov/uploadedfiles/TvisWebReports/Documents/FADResourceDocument.pdf
- Title V Maternal and Child Health Services Block Grant Program, mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program
- Title V MCH Services Block Grant Program Resource Page, mchb.tvisdata.hrsa.gov/Home/Resources

National Maternal and Child Oral Health Resource Center, www.mchoralhealth.org

- Title V MCH Services Block Grant Oral Health Toolkit, www.mchoralhealth.org/titlevbg/index.php
- Oral Health Care During Pregnancy: A National Consensus Statement, www.mchoralhealth.org/materials/consensus_statement.php

Contacts

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Section 1: Introduction

A. Document Purpose

The purpose of this user guide is to provide guidance on implementing oral health quality indicators (also referred to as measures) for the maternal and child health (MCH) population (MCH oral health quality indicators). This user guide provides guidance for reporting on indicators during 2019.[1]

B. Background

The Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), awarded a cooperative agreement for the National Maternal and Child Center for Oral Health Systems Integration and Improvement (COHSII) to the National Maternal and Child Oral Health Resource Center (OHRC) at Georgetown University. The purpose of COHSII is to lead a consortium of partners that includes OHRC in collaboration with the Association of State and Territorial Dental Directors (ASTDD) and the Dental Quality Alliance (DQA) to work with key stakeholders to support quality improvement (QI) and a patient-centered approach in existing systems of care that addresses the comprehensive oral health needs of the MCH population.

COHSII established a Quality Indicators Advisory Team (QIAT) to identify a set of MCH oral health quality indicators to monitor and improve oral health care services delivered to the MCH population in public health programs and systems of care. The QIAT identified these indicators by developing a quality measurement and performance improvement framework, conducting a broad environmental scan of existing oral health care quality indicators, and using a consensus-based process to determine the indicator set (see www.mchoralhealth.org/cohsii/quality.php).

The framework (Figure 1) identifies domains for measurement and improvement at different levels of reporting, including care (e.g., practice level), community, and systems (e.g., program, population) levels. The MCH oral health quality indicators are **national indicators;** their scores are calculated using data sources collected at the **state level** (e.g., state Medicaid program, state oral health program). Indicators were identified based on their potential to drive meaningful improvements in quality and on their near-term implementation feasibility.

[1] 2019 represents when indicators are reported and not when data for indicators were collected. Data-collection timeframes vary by indicator and are noted within the specifications for each indicator.

Figure 1. Framework for Oral Health Quality Performance Measurement and Improvement

DOMAIN	System	Community-Based Systems and Supports	Care
ACCESS	Eligibility Provider availability	Transportation	Provider availability Appointment availability
UTILIZATION	Use of services Site of care	Use of services Site of care	Scope of services Use of services Site of care
STRUCTURE	Leadership coordination Health information technology Transitions to adulthood Provider training Scope of benefits Level of funding Policy linked with evidence Facilities and equipment	Facilitating service-delivery programs in community sites Health information technology Supportive environment in a medical-dental neighborhood based on needs	Leadership coordination Service-delivery partnerships in community sites Health information technology Provider training Coding
PROCESS	Enrollment Person-/family- centered care Population education Case management	Enrollment (outreach) Person-/family- centered care Community needs assessment Case management	Enrollment (assistance) Person-/family- centered care Culturally competent care Case management Evidence-based care Referral
OUTCOME	Health status (population) Patient-reported outcomes Health care system experience Health literacy	Health status (community) Patient-reported outcomes Health care system experience Health literacy	Health status (individual) Patient-reported outcomes Care experience Health literacy

C. Maternal and Child Health Oral Health Quality Indicators

The MCH oral health quality indicators span the quality domains of access, utilization, process, and outcome shown in Figure 1, above. The indicators are grouped by two MCH sub-populations: (1) women of child-bearing age and pregnant women and (2) children. The indicators are summarized below. Detailed specifications are provided in section 3.

Summary of Quality Indicators for Women of Child-Bearing Age and Pregnant Women

Access
- Percentage of pregnant women reporting difficulty getting dental care (Data source: PRAMS)
- Percentage of pregnant women who had insurance to cover dental care during pregnancy (Data source: PRAMS)

Utilization
- Percentage of pregnant women who reported having their teeth cleaned by a dentist or dental hygienist during pregnancy (Data source: PRAMS)
- Percentage of women of child-bearing age (18–44 years) who report having a visit to a dentist or dental clinic in the past year (Data source: BRFSS)

Outcome
- Percentage of pregnant women reporting that they needed to see a dentist for a problem during pregnancy (Data source: PRAMS)

Summary of Quality Indicators for Children

Access
- Dentists who actively participate in Medicaid per 1,000 EPSDT-eligible enrolled children (Data source: Medicaid enrollment and claims)

Utilization
- Percentage of children who had a dental visit in the last 12 months (Data source: Medicaid enrollment and claims)
- Percentage of children at elevated risk receiving preventive dental services (Data source: Medicaid enrollment and claims)

Process
- Percentage of children at elevated risk receiving at least two topical fluoride applications as a dental service (Data source: Medicaid enrollment and claims)
- Percentage of children at elevated risk receiving at least two topical fluoride applications as an oral health service (Data source: Medicaid enrollment and claims)
- Percentage of children age 6–9 years at elevated risk who receive sealants in their permanent first molars (Data source: Medicaid enrollment and claims)
- Percentage of children age 10–14 years at elevated risk who receive sealants in their permanent second molars (Data source: Medicaid enrollment and claims)

Outcome

- Percentage of kindergarten children with dental caries experience (treated or untreated tooth decay) (Data source: Basic Screening Survey [BSS])
- Percentage of third-grade children with dental caries experience (treated or untreated tooth decay) (Data source: BSS)
- Percentage of kindergarten children with urgent dental treatment needs (Data source: BSS)
- Percentage of third-grade children with urgent dental treatment needs (Data source: BSS)

D. Level of Measurement

Quality indicators can be reported at different levels, and the framework (Figure 1) supports measurement across all levels of care, spanning from the point of care to the broader systems level. The Dental Quality Alliance notes that "standardized measurement that is aligned across public and private sectors and harmonized across different levels of reporting aggregation can help pave the way to improvement. Starting with broad populations, national goals guide the development of program-level measures, which are then used to derive practice- and clinician-level measures."[2] Thus, achieving improvement at the broader systems level using the MCH oral health quality indicators requires engagement of stakeholders and alignment of measures across all system levels (Figure 2).

Figure 2. Measurement Alignment Across Reporting Levels

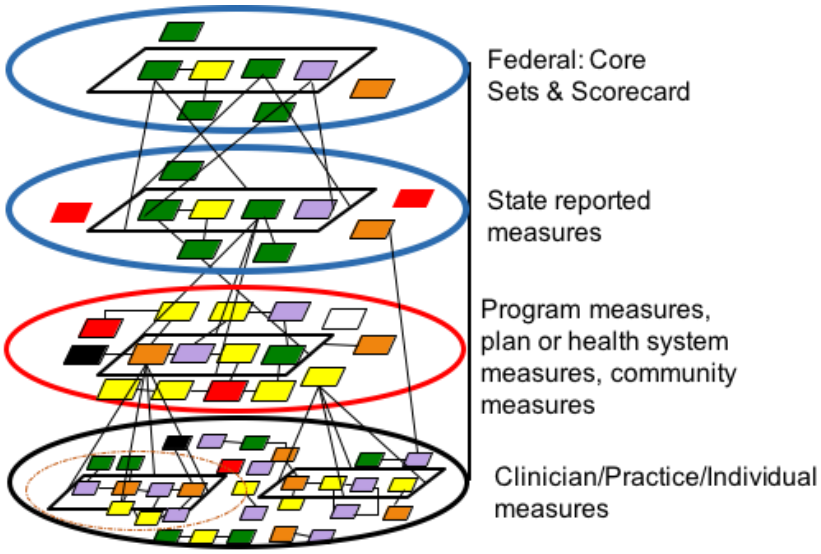

Figure source adapted from Mary S. Applegate (Medicaid medical director, Ohio), adapted from Bojestig, M; Jonkoping County Council, Sweden. 2011. *Making system wide improvement in health care.* [PowerPoint slides]. www3.ha.org.hk/haconvention/hac2011/proceedings/pdf/Plenary%20Sessions/P3.2.pdf

[2] Dental Quality Alliance. 2019. *Quality Measurement in Dentistry: A Guidebook.* Chicago: IL: American Dental Association. www.ada.org/~/media/ADA/DQA/2019_Guidebook.pdf?la=en

E. Intended Use and Implementation Considerations

The MCH oral health quality indicators comprise a **standardized** set of indicators that can be reported across state MCH programs to support and align oral health quality improvement efforts at the local, state, and national levels. The indicators can enable better assessments of current performance that can be used to set improvement goals and monitor progress made toward achieving those goals.

Section 2: Feasibility Assessment: Evaluating Readiness to Measure

Before beginning to report on the MCH oral health quality indicators, it is recommended that state MCH programs conduct a feasibility assessment to determine what can be measured in the near term and what will require building data collection and reporting capacity.

Recommended steps for conducting and using such an assessment are presented below.

A. Assemble Quality Indicator and Improvement Team: Engage Key Stakeholders

Because the quality indicators rely on different data sources that are likely governed by different state agencies (e.g., state Medicaid program, state department of health), it is important to engage these state stakeholders together in the feasibility assessment and indicator implementation processes.

B. Conduct Feasibility Assessment

Questions to consider when conducting a feasibility assessment include:

- What data are currently collected?
- What data are not collected?
- What steps need to be taken to collect new data?
- What capacity is there to calculate indicator scores?
- What infrastructure building may be needed to increase capacity to calculate indicator scores?
- What other state agencies need to be engaged in data collection and calculation of indicator scores?
- Are all key stakeholders engaged that need to be?

Appendix 1 provides a sample feasibility assessment tool that state MCH programs can use to evaluate their readiness to use the recommended set of MCH oral health quality indicators.

C. Use Findings from Feasibility Assessment to Develop an Action Plan

It is important to develop an action plan with specific time-based goals to obtain the data necessary to report on MCH oral health quality indicators and the capacity to use those data to report on the quality indicators.

Note: *As pilot states implement the indicators, we will incorporate information on common implementation barriers and examples of strategies used to overcome those barriers.*

Section 3: General Guidelines for Data Collection, Preparation, and Reporting

1. Data Sources and Critical Data Elements

Data sources refer to state-level data-collection systems and associated databases containing data that form the basis for calculating indicator scores. Critical data elements are the specific data elements, or variables, within a particular data source that are required to calculate a specific indicator score. Below is a summary of data sources and critical data elements required to calculate MCH oral health quality indicator scores.

Data Source: PRAMS, Surveillance Year 2017 (www.cdc.gov/prams/index.htm)

Critical Data Elements

Phase 8 Core Question
17. During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?
Phase 8 Standard Questions
Y6. Did any of the following things make it hard for you to go to a dentist or dental clinic during your most recent pregnancy?
Y7. This question is about other care of your teeth during your most recent pregnancy.

Data Source: BRFSS, Surveillance Year 2016 (www.cdc.gov/brfss/index.html)

Note: The oral health core set of questions is a rotating core that is included in BFRSS in even-numbered years.

Critical Data Elements

Section 7: Oral Health
7.1. How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.
Section 8: Demographics
8.1. Are you . . .[male/female/refused]
8.2. What is your age?

Data Source: Medicaid Enrollment and Claims Data, Calendar Year 2017

Critical Data Elements

Enrollment database	Claims database
• Member ID • Date of birth • Enrollment start and end dates • Program-eligibility category	• Member ID • Date of service • CDT codes • Tooth number • National Uniform Claim Committee health care provider taxonomy codes • National provider identifier • Provider billed amounts

Source: Basic Screening Survey (BSS), Association of State and Territorial Dental Directors (ASTDD) (www.astdd.org/basic-screening-survey-tool)

Critical Data Elements

Kindergarten
• Children screened
• Caries experience (treated or untreated decay)
• Untreated decay
• Needs urgent dental care
Third-grade Children
• Children screened
• Caries experience (treated or untreated decay)
• Untreated decay
• Needs urgent dental care

2. Time Frame

This user guide is for **data-collection year 2017** or the most recent prior year for which data are available:

- **Medicaid enrollment and claims data:** enrollment and service dates in 2017
- **PRAMS:** birth year and surveillance year is 2017
- **BFRSS:** survey collection year is 2016 (oral health module is a rotating core collected only in even years)
- **BSS kindergarten survey:** Data-collection year is school year 2016–2017 or most recent available (ASTDD guidance recommends that states conduct this survey every 5 years)
- **BSS third-grade survey:** Data-collection year is school year 2016–2017 or most recent available (ASTDD guidance recommends that states conduct this survey every 5 years)

3. Level of Reporting

MCH oral health quality indicator scores are calculated at population and systems (e.g., Medicaid program or dental plan) levels (see table below). The technical specifications for each indicator indicate the applicable reporting level. Reporting on the indicator at levels other than that for which it was intended may not be reliable.

Data Source	Level of Reporting
PRAMS	Population—state sample of women who delivered a live-born infant
BRFSS	Population—state sample of adults age 18 years and older
Medicaid/CHIP administrative data	Program—children enrolled in state Medicaid or CHIP program
BSS	Population—state sample of kindergarten children and third-grade children, respectively

4. Included Populations and Age Eligibility

General age eligibility follows approaches used by DQA for oral health quality measurement (www.ada.org/~/media/ADA/DQA/2019AdultMeasuresUserGuide.pdf?la=en).

Children may include individuals up to, but not including, age 21 (<21 years) to be consistent with Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligibility and the Medicaid Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.

Adults may include 18 years as the lower age bound consistent with the lower age bound included in the Medicaid Core Set of Adult Health Care Quality Measures.

Women of child-bearing age is frequently defined as women age 15–44 years. For the purposes of indicator score calculation, the age range of 18–44 years is used to be consistent with BRFSS reporting.

The age ranges for pediatric indicators and adult indicators may overlap. The applicable age range for each indicator is indicated within the technical specifications.

5. Data Collection and Quality

The Centers for Disease Control and Prevention (CDC) provides guidance for conducting, analyzing, and reporting BRFSS and PRAMS data.[3,4]

ASTDD provides guidance for conducting, analyzing, and reporting BSS data.[5]

DQA provides guidance for assessing data quality and promoting reliable implementation of measures using administrative enrollment and claims data.[6]

In addition to following the above guidance, before calculating indicator scores, implementers should evaluate and report on the extent of missing or invalid data contained within each data source, particularly for critical data elements and stratification data elements. *Stratification data elements* are those specific data elements, or variables, used to calculate separate indicator scores by the characteristics of the population that is the focus of the measure (i.e., included in the indicator denominator), such as age, race, ethnicity, or geographic location. *Missing* data refer to not having a value filled for the data element (may include unknown and refused values for survey-based data sources). Invalid data refer to filled values that do not represent legitimate values for that field (e.g., a code entered in the procedure code data element field that is not among the recognized set of procedure codes). For

[3] Centers for Disease Control and Prevention. 2019. *Behavioral Risk Factor Surveillance System* [webpage]. www.cdc.gov/brfss
[4] Centers for Disease Control and Prevention. 2019. *PRAMS* [webpage]. www.cdc.gov/prams/index.htm
[5] Association of State and Territorial Dental Directors. N.d. *ASTDD Basic Screening Surveys* [webpage]. www.astdd.org/basic-screening-survey-tool
[6] Dental Quality Alliance. 2019. *Program/Plan Level Dental Quality Measures* [webpage]. www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-development-reports/dqa-dental-quality-measures

any indicator or indicator stratification with a data element that has missing or invalid values of more than 10% of data, the reasons for missing or invalid data should be explored and improved data completeness and quality should be sought as part of overall quality improvement efforts. As indicated below, the extent of missing and invalid data should be included in indicator data reports.

6. Stratification

Following DQA guidelines,[7] to identify disparities and inform quality improvement efforts, the indicator scores should be stratified by population characteristics, when possible. *Stratification* refers to calculating separate indicator scores by the characteristics of the population that is the focus of the measurement (i.e., individuals eligible for inclusion in the indicator's denominator). Stratification variables may include age, race, ethnicity, geographic location, socioeconomic status, and program eligibility (e.g., Title V). To stratify indicators, "the denominator population is divided into mutually exclusive subsets based on the population characteristic of interest (e.g., age, race, ethnicity, or geographic location), and the rates are reported for each sub-population."[8]

Race and Ethnicity Stratifications

To promote consistency in the race/ethnicity categories reported across the set of MCH oral health quality Indicators, all indicators should include overall scores as well as stratification scores by the following aggregated and **mutually exclusive** race and ethnicity categories:

- Hispanic
- Non-Hispanic White
- Non-Hispanic Black
- Non-Hispanic other race or multiple race

Individuals should be classified as only one of the above categories. Individuals who select Hispanic ethnicity alone or in combination with any race category should be classified as Hispanic. Non-Hispanic individuals who select more than one race category should be classified as multiple race.

Separate detailed race/ethnicity breakouts by the following mutually exclusive categories are encouraged if sample size permits:

- Hispanic
- Non-Hispanic White
- Non-Hispanic Black
- Non-Hispanic American Indian/Alaska Native
- Non-Hispanic Asian
- Non-Hispanic Native Hawaiian/Other Pacific Islander
- Non-Hispanic multiple race
- Non-Hispanic other race (single other race)

[7] Dental Quality Alliance. 2019. *User Guide for Pediatric Measures Calculated Using Administrative Claims Data.* Chicago, IL: Dental Quality Alliance. www.ada.org/~/media/ADA/DQA/2019DQAPediatricMeasuresUserGuide.pdf?la=en

States should evaluate the extent to which race and ethnicity information are missing (see the preceding section). The percentage of missing or invalid values should be reported with the report on stratifications (see following section).

7. Reporting Missing and Invalid Data

The extent of missing and invalid data should be included in indicator data reports. For any indicator or indicator stratification with a data element missing more than 10% of data, it should be explicitly noted that the indicator/stratification should be interpreted with caution, and the percentage of missing data for the relevant data element(s) should be identified.

8. Minimum Denominator Size and Data Suppression

When indicators are stratified, the number of individuals in the denominator may be small. States should follow their own data-suppression methodologies, provide a reporting note for any cells that fall below the data-suppression threshold, and specify the threshold value. For example: NR=Not reportable due to respondent count of less than XX.

9. Guidance for Indicators Reported on Using Specific Data Sources

Indicators Reported on Using PRAMS Data

Response Rate Thresholds

CDC's minimum overall response rate threshold is set at 55% for the release of PRAMS data for public reporting purposes.[8] If the response rate threshold was not met for the reporting year, the measure can be used for internal use to support quality improvement efforts but not for public reporting. States not meeting the threshold are encouraged to adopt strategies to improve their response rates. There are a range of incentives and rewards that states have used to improve response rates on PRAMS surveys.[9]

Indicators Reported on Using Administrative Enrollment and Claims Data

Included Populations

States should seek to report on these measures for all children for whom administrative enrollment and claims data are available. All states should have claims data for children enrolled in Medicaid and CHIP. States with all-payer claims databases that incorporate dental services are encouraged to report on a broader population of children and to stratify results by source of coverage (e.g., Medicaid, CHIP, commercial plans).

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[8] Centers for Disease Control and Prevention. 2019. *Are PRAMS Data Available to Outside Researchers* [webpage]. www.cdc.gov/prams/prams-data/researchers.htm

[9] Shulman HB, D'Angelo DV, Harrison L, Smith RA, Warner L. 2018. The Pregnancy Risk Assessment Monitory System (PRAMS): Overview of design and methodology. *American Journal of Public Health*;108(10):1305–1313. www.cdc.gov/prams/pdf/methodology/PRAMS-Design-Methodology-508.pdf

Enrollment Requirements for DQA Measures

Based on testing data, DQA elected to use the 180-day continuous enrollment requirement for most of its access and process measures "to balance sufficient enrollment duration to allow children adequate time to access care with the number of children who are excluded from the denominator due to stricter enrollment requirements." This enrollment interval differs from the 90-day continuous-eligibility criteria for Centers for Medicare & Medicaid Services (CMS) EPSDT reporting. DQA's *2018 Pediatric Measures User Guide* notes: "CMS and other stakeholders (e.g., state Medicaid programs and state Marketplaces) have adopted DQA measures. The 180-day enrollment interval has not been cited as a barrier to implementation although it has been recognized as a distinction from the CMS EPSDT data reporting requirements."[10] Measure implementers interested in making comparisons to CMS EPSDT data or in further evaluating the impact of enrollment requirements can conduct their own sensitivity analyses using different enrollment lengths. However, these alternative enrollment lengths should not be used for MCH oral health quality indicator reporting. For more information on enrollment requirements for these measures, see the DQA user guide (www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2018_Pediatric_%20Measures_User_Guide.pdf?la=en).

[10] Dental Quality Alliance. 2019. *User Guide for Pediatric Measures Calculated Using Administrative Claims Data.* Chicago, IL: Dental Quality Alliance. www.ada.org/~/media/ADA/DQA/2019DQAPediatricMeasuresUserGuide.pdf?la=en

Section 4. Technical Specifications: Oral Health Quality Indicators for Women of Child-Bearing Age and Pregnant Women

Indicator Domain: ACCESS

Indicator W.1. Percentage of Pregnant Women Reporting Difficulty Getting Dental Care

Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System (PRAMS), www.cdc.gov/prams/index.htm

1. Description

Percentage of pregnant women reporting difficulty getting dental care

- **Numerator:** Number indicating "yes" to any of the response options for Phase 8, standard question Y6
- **Denominator:** Number responding to question Y6; exclude unknowns and refusals

Phase 8, Standard Question Y6
Did any of the following things make it hard for you to go to a dentist or dental clinic during *your most recent* pregnancy? For each item, check No if it was not something that made it hard for you to go to a dentist during pregnancy or Yes if it was.

- I could not find a dentist or dental clinic that would take pregnant patients
- I could not find a dentist or dental clinic that would take Medicaid patients
- I did not think it was safe to go to the dentist during pregnancy
- I could not afford to go to the dentist or dental clinic

2. Framework Domain

Access

- Provider availability: The availability of providers to ensure that benefits for beneficiaries are accessible without unreasonable travel or time delays
- Scope of services: Range of services provided to pregnant women and children of various ages

3. Level of Reporting

This is a state-level, population-based measure of resident women within the state who recently gave birth to a live-born infant during the surveillance year.

4. Data Source

PRAMS is a mixed-mode (mail and telephone) surveillance system.[11]

5. Data Elements

Critical Data Elements	
Phase 8, standard question Y6	Did any of the following things make it hard for you to go to a dentist or dental clinic during *your most recent* pregnancy? For each item, check No if it was not something that made it hard for you to go to a dentist during pregnancy or Yes if it was.
Available Stratification Elements[12]	
Maternal age (from birth certificate)	<20 Years 20–24 Years 25–29 Years 30–34 Years ≥35 Years
Race/ethnicity, detailed (from birth certificate)	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic American Indian/Alaska Native Non-Hispanic Asian Non-Hispanic Native Hawaiian/Other Pacific Islander Non-Hispanic multiple race Non-Hispanic other race (single other race)
Race/ethnicity, collapsed (from birth certificate)	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic other/multiple race
Educational attainment (from birth certificate)	Less than high school High school graduate More than high school (some college or more)
Health insurance (principal source of payment for delivery; only available for states with the 2003 revision to the U.S. certificate of live birth)	Medicaid/CHIP Other coverage (private, other public) None/uninsured/self-pay
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Yes No

[11] Centers for Disease Control and Prevention. 2018. *Methodology* [webpage]. www.cdc.gov/prams/methodology.htm

[12] Adapted from Health Resource and Services Administration, Maternal and Child Health Bureau. 2018. *Federally Available Data (FAD) Resource Document.* Rockville, MD: Health Resource and Services Administration, Maternal and Child Health Bureau. mchb.tvisdata.hrsa.gov/uploadedfiles/Documents/FADResourceDocument.pdf

participation (birth certificate; from PRAMS survey before 2016)	
Marital status (from birth certificate)	Married Unmarried/other

6. Measure Guidance

When calculating this measure score, states should use the weighted data provided to them by CDC. This measure should be publicly reported only if the state met the PRAMS response rate threshold of 55% specified by CDC.[13] If the response rate threshold was not met, the measure can be used for internal use to support quality improvement efforts. To improve response rates, states can use a range of incentives and rewards.[14]

7. Measure Calculation: Detailed Specification

A. Denominator

Step 1. Determine the number responding to Phase 8, standard question Y6.

Step 2. Exclude unknowns and refusals.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Number of respondents answering question Y6

B. Numerator

Step 1. Determine the number indicating "yes" to any of the four response options for Phase 8, standard question Y6:

Count respondent in numerator if she said "yes" to:

- "I could not find a dentist or dental clinic that would take pregnant patients"

OR

- "I could not find a dentist or dental clinic that would take Medicaid patients"

OR

- "I did not think it was safe to go to the dentist during pregnancy"

OR

- "I could not afford to go to the dentist or dental clinic"

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Respondents who reported difficulty getting dental care

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[13] Centers for Disease Control and Prevention. 2019. *Are PRAMS Data Available to Outside Researchers* [webpage]. www.cdc.gov/prams/prams-data/researchers.htm

[14] Shulman HB, D'Angelo DV, Harrison L, Smith RA, Warner L. 2018. The Pregnancy Risk Assessment Monitory System (PRAMS): Overview of design and methodology. *American Journal of Public Health* 108(10):1305–1313. www.cdc.gov/prams/pdf/methodology/PRAMS-Design-Methodology-508.pdf

C. Denominator Exclusions/Exceptions

Missing responses and refusals.

D. Reporting Stratifications

a. Maternal Age (<20, 20–24, 25–29, 30–34, ≥35)
b. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, Non-Hispanic multiple race)
c. Educational attainment (less than high school, high school graduate, more than high school)
d. Health insurance (Medicaid, other [private, other public], none)
e. WIC participation (yes, no)
f. Marital status (married, unmarried/other)

E. Optional Reporting Stratifications

a. Detailed race/ethnicity if sample size permits (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian Non-Hispanic Native Hawaiian/Other Pacific Islander, Non-Hispanic other race, Non-Hispanic multiple race)

F. Measure Score

Report:

a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted
e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Measure score, weighted, stratified by [optional reporting stratification] with 95% confidence intervals and unweighted denominator count
i. Response rate for overall survey

Note: States should follow their own data-suppression methodologies, provide a reporting note for any cells that fall below the data-suppression threshold, and specify the threshold value. For example: NR=Not reportable due to respondent count of less than XX.

8. Limitations

Indicator limitations are as follows. (1) PRAMS data are collected only from women who delivered a live-born infant, not from all women of reproductive age, and from 40 states and one city, not from the entire United States. (2) PRAMS data are self-reported and may be subject to recall bias and under-reporting or over-reporting of behaviors based on social desirability. (3) Self-report surveys such as PRAMS may be subject to systematic error resulting from non-coverage (e.g. lower landline telephone coverage due to transition to cellular-telephone-only households, undeliverable addresses), nonresponse (e.g. refusal to participate in the survey or to

answer specific questions), or measurement bias (e.g. recall bias). However, PRAMS attempts to contact potential respondents by mail and landline or cellular telephone to increase response rates. (4) Women with fetal death or abortion are excluded from PRAMS. (5) PRAMS estimates cover only the population of women in each state who also deliver in that state; therefore, women who delivered in a different state are not captured in their resident state.[15]

9. Additional Notes

This indicator is not an existing, specified indicator. It was created for the MCH oral health quality indicators from the PRAMS survey. Additional information on PRAMS is available at www.cdc.gov/prams/index.htm.

[15] Centers for Disease Control and Prevention. 2015. *Chronic Disease Indicators: Indicator Definitions—Oral Health* [webpage]. www.cdc.gov/cdi/definitions/oral-health.html

Indicator Domain: ACCESS

Indicator W.2. Percentage of Pregnant Women Who Had Insurance to Cover Dental Care During Pregnancy

Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System (PRAMS)

1. Description

Percentage of pregnant women reporting that they had insurance to cover dental care during pregnancy

- **Numerator:** Number indicating "yes" to the response option: "I had insurance to cover dental care during my pregnancy"
- **Denominator:** Number responding "yes" or "no" to standard question Y7, response option "I had insurance to cover dental care during my pregnancy"; exclude unknowns and refusals

Phase 8, Standard Question Y7

This question is about the care of your teeth *during your most recent pregnancy*. For each item, check No if it is not true or does not apply to you or Yes if it is true.

- I knew it was important to care for my teeth and gums during my pregnancy
- A dental or other health care worker talked with me about how to care for my teeth and gums
- I had my teeth cleaned by a dentist or dental hygienist
- I had insurance to cover dental care during my pregnancy
- I needed to see a dentist for a **problem**
- I went to a dentist or dental clinic about a **problem**

2. Framework Domain

Access

- Eligibility: Clear policies and user-friendly tools to support eligibility verification and continuity of eligibility in private and public programs[16]
- Scope of services: Range of services provided to pregnant women and children of various ages

[16] Definitions adapted from Association of Maternal and Child Health Programs. 2014. *Standards for Systems of Care for Children and Youth with Special Health Care Needs*. Washington, DC: Association of Maternal and Child Health Programs. http://www.amchp.org/AboutTitleV/Resources/Documents/Standards%20Charts%20FINAL.pdf

3. Level of Reporting

This is a state-level, population-based measure of resident women within the state who recently gave birth to a live-born infant during the surveillance year.

4. Data Source

PRAMS is a mixed-mode (mail and telephone) surveillance system.[17]

5. Data Elements

Critical Data Elements	
Phase 8, standard question Y7	This question is about the care of your teeth during your most recent pregnancy. For each item, check No if it is not true or does not apply to you or Yes if it is true.
Available Stratification Elements[18]	
Maternal age (from birth certificate)	<20 Years 20-24 Years 25-29 Years 30-34 Years ≥35 Years
Race/ethnicity, detailed (from birth certificate)	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic American Indian/Alaska Native Non-Hispanic Asian Non-Hispanic Native Hawaiian/Other Pacific Islander Non-Hispanic Multiple Race Non-Hispanic Other Race (single other race)
Race/ethnicity, collapsed (from birth certificate)	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic Other/Multiple Race
Educational attainment (from birth certificate)	Less than high school High school graduate More than high school (some college or more)
Health insurance (principal source of payment for delivery; only available for states with the 2003 revision to the U.S. certificate of live birth)	Medicaid/CHIP Other coverage (private, other public) None/Uninsured/Self-Pay

[17] Centers for Disease Control and Prevention. 2018. *Methodology* [webpage]. www.cdc.gov/prams/methodology.htm

[18] Adapted from Health Resources and Services Administration, Maternal and Child Health Bureau. 2018. *Federally Available Data (FAD) Resource Document.* Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau. mchb.tvisdata.hrsa.gov/uploadedfiles/Documents/FADResourceDocument.pdf

WIC participation (birth certificate; from PRAMS survey prior to 2016)	Yes No
Marital status (from birth certificate)	Married Unmarried/Other

6. Measure Guidance

When calculating this measure score, states should use the weighted data provided to them by CDC. This measure should be publicly reported only if the state met the PRAMS response rate threshold of 55% specified by CDC.[19] If the response rate threshold was not met, the measure can be used for internal use to support quality improvement efforts. To improve response rates, states can use a range of incentives and rewards.[20]

7. Measure Calculation: Detailed Specification

A. Denominator

Step 1. Determine the number responding "yes" or "no" to Phase 8, standard question Y7, response option "I had insurance to cover dental care during my pregnancy."

Step 2. Exclude unknowns and refusals.

Note: Base denominator inclusion on responses to the specific response option "I had insurance to cover dental care during my pregnancy" and not on whether the person answered any of the response options in question Y7.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Number of respondents who provided a response to the response option "I had insurance to cover dental care during my pregnancy" of Phase 8, standard question Y7

B. Numerator

Step 1. Determine the number indicating "yes" to the response option: "I had insurance to cover dental care during my pregnancy."

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Respondents who reported they had insurance to cover dental care during pregnancy

C. Denominator Exclusions/Exceptions

Missing responses and refusals.

D. Reporting Stratifications

a. Maternal Age (<20, 20–24, 25–29, 30–34, ≥35)

[19] Centers for Disease Control and Prevention. 2019. *Are PRAMS Data Available to Outside Researchers* [webpage]www.cdc.gov/prams/prams-data/researchers.htm

[20] Shulman HB, D'Angelo DV, Harrison L, Smith RA, Warner L. 2018. The Pregnancy Risk Assessment Monitory System (PRAMS): Overview of design and methodology. *American Journal of Public Health*; 108(10):1305–1313. www.cdc.gov/prams/pdf/methodology/PRAMS-Design-Methodology-508.pdf

b. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, Non-Hispanic multiple race)
c. Educational attainment (less than high school, high school graduate, more than high school)
d. Health insurance (Medicaid, other [private, other public], none)
e. WIC participation (yes, no)
f. Marital status (married, unmarried/other)

E. Optional Reporting Stratifications

a. Detailed race/ethnicity if sample size permits (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian, Non-Hispanic Native Hawaiian/other Pacific Islander, Non-Hispanic other race, Non-Hispanic multiple race)

F. Measure Score

Report:

a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted
e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Measure score, weighted, stratified by [optional reporting stratification] with 95% confidence intervals and unweighted denominator count
i. Response rate for overall survey

Note: States should follow their own data-suppression methodologies, provide a reporting note for any cells that fall below the data suppression threshold, and specify the threshold value. For example: NR=Not reportable due to respondent count of less than XX.

8. Limitations

Indicator are as follows. (1) PRAMS data are collected only from women who delivered a live-born infant, not from all women of reproductive age, and from 40 states and one city, not from the entire United States. (2) PRAMS data are self-reported and may be subject to recall bias and under-reporting or over-reporting of behaviors based on social desirability. (3) Self-report surveys such as PRAMS may be subject to systematic error resulting from non-coverage (e.g. lower landline telephone coverage due to transition to cellular-telephone-only households or undeliverable addresses), nonresponse (e.g. refusal to participate in the survey or to answer specific questions), or measurement bias (e.g. recall bias). However, PRAMS attempts to contact potential respondents by mail and landline or cellular telephone to increase response rates. (4) Women with fetal death or abortion are excluded from PRAMS. (5) PRAMS estimates cover only the population of women in

each state who also deliver in that state; therefore, women who delivered in a different state are not captured in their resident state.[21]

9. Additional Notes

This indicator is not an existing, specified indicator. It was created for the MCH oral health quality indicators from the PRAMS survey. Additional information on PRAMS is available at www.cdc.gov/prams/index.htm.

[21] Centers for Disease Control and Prevention. 2015. *Chronic Disease Indicators: Indicator Definitions—Oral Health* [webpage]. www.cdc.gov/cdi/definitions/oral-health.html

Indicator Domain: UTILIZATION

Indicator W.3. Percentage of Pregnant Women Who Reported Having Their Teeth Cleaned by a Dentist or Dental Hygienist During Pregnancy

Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System (PRAMS), www.cdc.gov/prams/index.htm

1. Description

Percentage of pregnant women reporting that they had their teeth cleaned by a dentist or dental hygienist during pregnancy

- **Numerator:** Number indicating "yes" to core question 17: "During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?"
- **Denominator:** Number responding "yes" or "no" to core question 17; exclude unknowns and refusals

Phase 8, Core Question 17
During *your most recent* pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?
- No
- Yes

2. Framework Domain

Utilization

- Use of services: Provision and utilization of services by a group of individuals identified by enrollment in a health plan or through use of clinical services[22]

3. Level of Reporting

This is a state-level, population-based measure of resident women within the state who recently gave birth to a live-born infant during the surveillance year.

4. Data Source

PRAMS is a mixed-mode (mail and telephone) surveillance system.[23]

5. Data Elements

Critical Data Elements

[22] National Quality Measures Clearinghouse. N.d. Guidelines and Measures. [webpage]. www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx
[23] Centers for Disease Control and Prevention. 2018. *Methodology* [webpage]. www.cdc.gov/prams/methodology.htm

Phase 8, core question 17	During *your most recent* pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?
Available Stratification Elements[24]	
Maternal age (from birth certificate)	<20 Years 20-24 Years 25-29 Years 30-34 Years ≥35 Years
Race/ethnicity, detailed (from birth certificate)	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic American Indian/Alaska Native Non-Hispanic Asian Non-Hispanic Native Hawaiian/other Pacific Islander Non-Hispanic multiple race Non-Hispanic other race (single other race)
Race/ethnicity, collapsed (from birth certificate)	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic other/multiple race
Educational attainment (from birth certificate)	Less than high school High school graduate More than high school (some college or more)
Health insurance (principal source of payment for delivery; only available for states with the 2003 revision to the U.S. certificate of live birth)	Medicaid/CHIP Other coverage (private, other public) None/uninsured/self-pay
WIC participation (from birth certificate) (from PRAMS survey prior to 2016)	Yes No
Marital status (from birth certificate)	Married Unmarried/other

6. Measure Guidance

When calculating this measure score, states should use the weighted data provided to them by CDC. This measure should be publicly reported only if the state met the PRAMS response rate threshold of 55% specified by CDC.[25] If the response rate threshold was not met, the measure can be used for internal use to support quality

[24] Adapted from Health Resources and Services Administration, Maternal and Child Health Bureau. 2018. *Federally Available Data (FAD) Resource Document.* Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau. mchb.tvisdata.hrsa.gov/uploadedfiles/Documents/FADResourceDocument.pdf

[25] Centers for Disease Control and Prevention. *PRAMS Data for Researchers* http://cdc.gov/prams/prams-data/researchers.htm.

improvement efforts. To improve response rates, states can use a range of incentives and rewards.[26]

7. Measure Calculation: Detailed Specification

A. Denominator

Step 1. Determine the number responding "yes" or "no" to Phase 8, core question 17, "During *your most recent* pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?"

Step 2. Exclude unknowns and refusals.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Number of respondents who provided a response to Phase 8, core question 17

B. Numerator

Step 1. Determine the number indicating "yes" to Phase 8, core question 17.

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Respondents who reported they had their teeth cleaned by a dentist or dental hygienist during pregnancy

C. Denominator Exclusions/Exceptions

Missing responses and refusals.

D. Reporting Stratifications

a. Maternal Age (<20, 20–24, 25–29, 30–34, ≥35)
b. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, or Non-Hispanic multiple race)
c. Educational attainment (less than high school, high school graduate, more than high school)
d. Health insurance (Medicaid, other [private, other public], None)
e. WIC participation (yes, no)
f. Marital status (married, unmarried/other)

E. Optional Reporting Stratifications

a. Detailed race/ethnicity if sample size permits (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian Non-Hispanic Native Hawaiian/other Pacific Islander, Non-Hispanic other race, Non-Hispanic multiple race)

F. Measure Score

Report:
a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted

[26] Shulman HB, D'Angelo DV, Harrison L, Smith RA, Warner L. 2018. The Pregnancy Risk Assessment Monitory System (PRAMS): Overview of design and methodology. *American Journal of Public Health*; 108(10):1305–1313. www.cdc.gov/prams/pdf/methodology/PRAMS-Design-Methodology-508.pdf

e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Measure score, weighted, stratified by [optional reporting stratification] with 95% confidence intervals and unweighted denominator count
i. Response rate for overall survey

Note: States should follow their own data-suppression methodologies, provide a reporting note for any cells that fall below the data-suppression threshold, and specify the threshold value. For example: NR=Not reportable due to respondent count of less than XX.

8. Limitations

Indicator limitations are as follows. (1) PRAMS data are collected only from women who delivered a live-born infant, not from all women of reproductive age, and from 40 states and one city, not from the entire United States. (2) PRAMS data are self-reported and may be subject to recall bias and under-reporting or over-reporting of behaviors based on social desirability. (3) Self-report surveys such as PRAMS may be subject to systematic error resulting from non-coverage (e.g. lower landline telephone coverage due to transition to cellular-telephone-only households, undeliverable addresses), nonresponse (e.g. refusal to participate in the survey or to answer specific questions), or measurement bias (e.g. recall bias). However, PRAMS attempts to contact potential respondents by mail and landline or cellular telephone to increase response rates. (4) Women with fetal death or abortion are excluded from PRAMS. (5) PRAMS estimates cover only the population of women in each state who also deliver in that state; therefore, women who delivered in a different state are not captured in their resident state.[27]

9. Additional Notes

This indicator is not an existing, specified indicator. It was created for the MCH oral health quality Indicators from the PRAMS survey. Additional information on PRAMS is available at www.cdc.gov/prams/index.htm.

[27] Centers for Disease Control and Prevention. 2015. *Chronic Disease Indicators: Indicator Definitions—Oral Health* [webpage]. www.cdc.gov/cdi/definitions/oral-health.html

Indicator Domain: UTILIZATION

Indicator W.4. Percentage of Women of Child-Bearing Age (18–44 years) Who Report Having a Visit to a Dentist or Dental Clinic in the Past Year

Source: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC) (www.cdc.gov/brfss/index.html)

1. Description

Percentage of women of child-bearing age (18–44 years) who report having a visit to a dentist or dental clinic in the past year

- **Numerator:** Number who report having been to the dentist or dental clinic within the past year
- **Denominator:** Number of female respondents, age 18–44 years; exclude unknowns and refusals

Section 7: Oral Health, Question 7.1
How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.
[Response options only read if necessary.]

- Within the past year (anytime less than 12 months ago)
- Within the past 2 years (1 year but less than 2 years ago)
- Within the past 5 years (2 years but less than 5 years ago)
- 5 or more years ago
- Don't know/not sure (do not read)
- Never (do not read)
- Refused (do not read)

2. Framework Domain

Utilization

- Use of services: Provision and utilization of services by a group of individuals identified by enrollment in a health plan or through use of clinical services[28]

3. Level of Reporting

This is a state-level, population-based measure of adults age 18 years and older residing within the state during the surveillance year.

[28] National Quality Measures Clearinghouse. 2019. *Guidelines and Measures Updates* [webpage]. www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx

4. Data Source

BRFSS uses a complex sampling design. When reporting this measure, states should use the weighted data provided to them by CDC.

5. Data Elements

Critical Data Elements	
Section 7: Oral Health	
2016 Surveillance Year, Section 7, Question 7.1.	How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.
Section 8: Demographics	
8.1.	Are you . . .[male/female/refused]
8.2.	What is your age?
Available Stratification Elements[29]	
Age	18–24 Years 25–34 Years 35–44 Years
Race/ethnicity, detailed	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic American Indian/Alaska Native Non-Hispanic Asian Non-Hispanic Native Hawaiian/other Pacific Islander Non-Hispanic other/multiple race
Race/ethnicity, collapsed	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic other/multiple race
Educational attainment	Less than high school High school graduate More than high school
Health insurance (current status)	Insured Uninsured
Marital status	Married Unmarried
Household income/poverty[30]	<$15,000 $15,000–$24,999 $25,000–$49,999 ≥$50,000
Language	English Non-English

[29] Adapted from Health Resources and Services Administration, Maternal and Child Health Bureau. 2018. *Federally Available Data (FAD) Resource Document.* Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau. mchb.tvisdata.hrsa.gov/uploadedfiles/Documents/FADResourceDocument.pdf

[30] The FAD document states: "Missing data exceeded 10%; interpret with caution."

(language of survey administration)	
Urban-rural residence[31] (MSA defined by Census Bureau)	MSA, central city MSA, non-central city Non-MSA
Disability	Activity limitations No activity limitations

6. Measure Guidance

When reporting on this measure, states should use the weighted data provided to them by CDC and report only if the state met the response rate threshold specified by CDC.

7. Measure Calculation: Detailed Specification

Note: The analyst must set the correct strata and weight variables. Strata are defined by the variable _STSTR and the primary weight is _LLCPWT, the weight for individuals in the combined landline and cellular telephone samples.

A. Denominator

Determine the number of women age 18–44 years who answered question 7.1:

Step 1: Identify number of respondents to question 7.1.

Step 2: Restrict to female respondents.

Step 3: Restrict to respondents age18–44 years.

Step 4: Exclude those who refused to answer, had a missing answer, or answered "don't know/not sure."

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Female respondents age 18–44 years

B. Numerator

Step 1: Determine the subset of the denominator (number of female respondents age 18–44 years) who reported having been to the dentist or dental clinic "within the past year (any time less than 12 months ago)."

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Female respondents age 18–44 years who reported having a dental visit within the past year

C. Denominator Exclusions/Exceptions

Missing responses, don't know/not sure responses, and refusals.

D. Reporting Stratifications

a. Age (18–24, 25–34, 35–44)

[31] The FAD document states: "Missing data exceeded 10%; interpret with caution."

b. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, Non-Hispanic multiple race)
c. Educational attainment (less than high school, high school graduate, more than high school)
d. Health insurance (insured, uninsured)
e. Household income (<$15,000, $15,000–$24,999, $25,000–$49,999)
f. Marital status (married, unmarried)
g. Language (English, non-English)
h. Urban-rural residence (MSA central city, MSA non-central city, non-MSA)

E. Optional Reporting Stratifications

a. Detailed race/ethnicity if sample size permits (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian, Non-Hispanic Native Hawaiian/other Pacific Islander, Non-Hispanic other race, Non-Hispanic multiple race)

F. Measure Score

Report:

a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted
e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Measure score, weighted, stratified by [optional reporting stratification] with 95% confidence intervals and unweighted denominator count
i. Response rate for overall survey

Note: States should follow their own data-suppression methodologies, provide a reporting note for any cells that fall below the data-suppression threshold, and specify the threshold value. For example: NR=Not reportable due to respondent count of less than XX.

8. Limitations

The oral health module is a rotating core that is included in the BRFSS core questionnaire only in even-numbered years.

As with all self-reported sample surveys, BRFSS data might be subject to systematic error resulting from noncoverage (e.g., on college campuses or in the military), nonresponse (e.g., refusal to participate in the survey or to answer specific questions), or measurement (e.g., social desirability or recall bias). To address some of these potential concerns, BRFSS began including cellular-telephone-only users in the 2011 data collection.[32]

[32] Centers for Disease Control and Prevention. 2015. *Chronic Disease Indicators: Indicator Definitions—Oral Health* [webpage]. www.cdc.gov/cdi/definitions/oral-health.html

9. Additional Notes

This indicator is adapted from CDC's Chronic Disease Indicators, Oral Health Indicator 1.1, "Visits to dentist or dental clinic among adults age ≥ 18 years."[33] This MCH oral health quality indicator is restricted to females age 18–44 years.

Additional information on the BRFSS is available at www.cdc.gov/brfss/index.html.

[33] Centers for Disease Control and Prevention. 2015. *Chronic Disease Indicators: Indicator Definitions—Oral Health* [webpage]. www.cdc.gov/cdi/definitions/oral-health.html

Indicator Domain: OUTCOME

Indicator W.5. Percentage of Pregnant Women Reporting That They Needed to See a Dentist for a Problem During Pregnancy

Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System (PRAMS), www.cdc.gov/prams/index.htm

1. Description

Percentage of pregnant women reporting that they needed to see a dentist for a problem during pregnancy

- **Numerator:** Number indicating "yes" to the response option: "I needed to see a dentist for a **problem**"
- **Denominator:** Number responding "yes" or "no" to question Y7, response option "I needed to see a dentist for a **problem**"; exclude unknowns and refusals

Phase 8, Standard Question Y7

This question is about the care of your teeth *during your most recent pregnancy*. For each item, check No if it is not true or does not apply to you or Yes if it is true.

- I knew it was important to care for my teeth and gums during my pregnancy
- A dental or other health care worker talked with me about how to care for my teeth and gums
- I had my teeth cleaned by a dentist or dental hygienist
- I had insurance to cover dental care during my pregnancy
- I needed to see a dentist for a **problem**
- I went to a dentist or dental clinic about a **problem**

2. Framework Domain

Outcome

- Care experience: Experience when a person seeks and receives care, including elements such as ease or difficulty in getting appointments, accessing information, and communicating with health care providers
- Patient-reported outcomes: Any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response

3. Level of Reporting

This is a state-level, population-based measure of resident women within the state who recently gave birth to a live-born infant during the surveillance year.

4. Data Source

PRAMS is a mixed-mode (mail and telephone) surveillance system.[34]

5. Data Elements

Critical Data Elements	
Phase 8, standard question Y7	This question is about the care of your teeth during your most recent pregnancy. For each item, check No if it is not true or does not apply to you or Yes if it is true.
Available Stratification Elements[35]	
Maternal age (from birth certificate)	<20 Years 20–24 Years 25–29 Years 30–34 Years ≥35 Years
Race/ethnicity, detailed (from birth certificate)	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic American Indian/Alaska Native Non-Hispanic Asian Non-Hispanic Native Hawaiian/other Pacific Islander Non-Hispanic Multiple race Non-Hispanic other race (single other race)
Race/ethnicity, collapsed (from birth certificate)	Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic Other/Multiple Race
Educational attainment (from birth certificate)	Less than high school High school graduate More than high school (some college or more)
Health insurance (principal source of payment for delivery; only available for states with the 2003 revision to the U.S. certificate of live birth)	Medicaid/CHIP Other coverage (private, other public) None/uninsured/self-pay
WIC participation (birth certificate; from PRAMS survey prior to 2016)	Yes No
Marital status (from birth certificate)	Married Unmarried/other

[34] Centers for Disease Control and Prevention. 2018. *Methodology* [webpage]. www.cdc.gov/prams/methodology.htm

[35] Adapted from Health Resources and Services Administration, Maternal and Child Health Bureau. 2018. *Federally available data (FAD) Resource Document.* Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau. mchb.tvisdata.hrsa.gov/uploadedfiles/Documents/FADResourceDocument.pdf

6. Measure Guidance

When calculating this measure score, states should use the weighted data provided to them by CDC. This measure should be publicly reported only if the state met the PRAMS response rate threshold of 55% specified by CDC.[36] If the response rate threshold was not met, the measure can be used for internal use to support quality improvement efforts. To improve response rates, states can use a range of incentives and rewards.[37]

7. Measure Calculation: Detailed Specification

A. Denominator

Step 1. Determine the number responding "yes" or "no" to Phase 8, standard question Y7, response option "I needed to see a dentist for a **problem**."

Step 2. Exclude unknowns and refusals.

Note: Base denominator inclusion on responses to the specific response option "I needed to see a dentist for a **problem**" and not on whether the person answered any of the response options in question Y7.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Number of respondents who provided a response to the response option "I needed to see a dentist for a problem" of Phase 8, standard question Y7

B. Numerator

Step 1. Determine the number indicating "yes" to the response option: "I needed to see a dentist for a **problem**."

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Respondents who reported they needed to see a dentist for a problem

C. Denominator Exclusions/Exceptions

Missing responses and refusals.

D. Reporting Stratifications

a. Maternal Age (<20, 20–24, 25–29, 30–34, ≥35)
b. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, Non-Hispanic multiple race)
c. Educational attainment (less than high school, high school graduate, more than high school)
d. Health insurance (Medicaid, other [private, other public], none)
e. WIC participation (yes, no)
f. Marital status (married, unmarried/other)

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[36] Centers for Disease Control and Prevention. 2019. *Are PRAMS Data Available to Outside Researchers* [webpage] www.cdc.gov/prams/prams-data/researchers.htm
[37] Shulman HB, D'Angelo DV, Harrison L, Smith RA, Warner L. 2018. The Pregnancy Risk Assessment Monitory System (PRAMS): Overview of design and methodology. *American Journal of Public Health*; 108(10):1305–1313. www.cdc.gov/prams/pdf/methodology/PRAMS-Design-Methodology-508.pdf

E. Optional Reporting Stratifications

a. Detailed race/ethnicity if sample size permits (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian Non-Hispanic Native Hawaiian/other Pacific Islander, Non-Hispanic other race, Non-Hispanic multiple race)

F. Measure Score

Report:

a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted
e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Measure score, weighted, stratified by [optional reporting stratification] with 95% confidence intervals and unweighted denominator count
i. Response rate for overall survey

Note: States should follow their own data-suppression methodologies, provide a reporting note for any cells that fall below the data-suppression threshold, and specify the threshold value. For example: NR=Not reportable due to respondent count of less than XX.

8. Limitations

Indicator limitations are as follows. (1) PRAMS data are collected only from women who delivered a live-born infant, not from all women of reproductive age, and from 40 states and one city, not from the entire United States. (2) PRAMS data are self-reported and may be subject to recall bias and under-reporting or over-reporting of behaviors based on social desirability. (3) Self-report surveys such as PRAMS may be subject to systematic error resulting from non-coverage (e.g. lower landline telephone coverage due to transition to cellular-telephone-only households, undeliverable addresses), nonresponse (e.g. refusal to participate in the survey or to answer specific questions), or measurement bias (e.g. recall bias). However, PRAMS attempts to contact potential respondents by mail and landline or cellular telephone to increase response rates. (4) Women with fetal death or abortion are excluded from PRAMS. (5) PRAMS estimates cover only the population of women in each state who also deliver in that state; therefore, women who delivered in a different state are not captured in their resident state.[38]

[38] Centers for Disease Control and Prevention. 2015. *Chronic Disease Indicators: Indicator Definitions—Oral Health* [webpage]. www.cdc.gov/cdi/definitions/oral-health.html

9. Additional Notes

This indicator is not an existing, specified indicator. It was created for the MCH oral health quality indicators from the PRAMS survey. Additional information on PRAMS is available at www.cdc.gov/prams/index.htm.

Section 4: Technical Specifications: Oral Health Quality Indicators for Children

Indicator Domain: ACCESS

Indicator C.1. Dentists Who Actively Participate in Medicaid per 1,000 EPSDT Eligible Enrolled Children

Source: Medicaid administrative enrollment and claims data

1. Description

Dentists who actively participate in Medicaid per 1,000 EPSDT eligible enrolled children

- **Numerator:** Number of dentists who bill $10,000 or more during the year for enrolled children eligible for the EPDST benefits in the state's Medicaid program
- **Denominator:** Number of EPSDT eligible enrolled children (in thousands)

2. Framework Domain

Access

- Provider availability: The availability of providers to ensure that benefits for beneficiaries are accessible without unreasonable travel or time delays

3. Level of Reporting

This is a state-level measure of provider participation in the state's Medicaid program for children.

4. Data Source

Medicaid administrative enrollment and claims data.

5. Critical Data Elements

Enrollment Database	Claims Database
• Member ID • Date of birth • Program eligibility category	• Member ID • Date of service • CDT codes • National Uniform Claim Committee health care provider taxonomy codes • National provider identifier • Provider billed amounts

6. Measure Guidance

[To be added after pilot implementation of this indicator.]

7. Measure Calculation: Detailed Specification

A. Denominator

Determine the number of children age <21 years enrolled in the state Medicaid program who were eligible for EPSDT benefits during the reporting year. Include all enrollees, regardless of enrollment length.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Number of EPSDT eligible enrolled children

B. Numerator

Step 1. Identify all claims for Medicaid-enrolled children (age <21years) eligible for EPSDT benefits.

Step 2. Using unique national provider identifiers for **rendering providers**, identify providers who have billed for at least one service for Medicaid ESPDT-eligible children. (Use the rendering provider number and not the billing provider number.)

Step 3. Sum the billed amounts for each provider for services provided to Medicaid EPSDT-eligible children during the year.

Step 4. Determine the number of providers whose billings to the Medicaid program for EPSDT-eligible children during the year totaled $10,000 or more.

Note 1: Duplicate claims should be deduplicated before step 3.

Note 2: In states with dental services provided through managed care organizations, coordinated care organizations, dental care organizations, or dental benefit administrators, states should request the information in steps 1–3 from the contracted entities and then sum the amounts for each provider to determine total billings.

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Providers who billed more than $10,000 to Medicaid for services provided to EPSDT-eligible children

C. Denominator Exclusions/Exceptions

Not applicable.

D. Measure Score

Report:

a. Number in denominator
b. Number in numerator
c. Measure rate (NUM/DEN) x 1,000

8. Limitations

This indicator does not delineate provider participation by geographic area or other factors that may be important to assessing provider availability and access to care. States may want to conduct a deeper analysis of this indicator to identify disparities in provider availability.

9. Additional Notes

This indicator is not an existing, specified indicator. It was created for the MCH oral health quality indicators.

Indicator Domain: UTILIZATION

Indicator C.2. Utilization of Services, Dental Services (NQF #2511)

Source: American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA). Please use the DQA website to access the specification details.

1. Description

Percentage of all enrolled children under age 21 who received at least one dental service within the reporting year

- **Numerator:** Unduplicated number of children who received at least one dental service
- **Denominator:** Unduplicated number of all enrolled children under age 21

2. Framework Domain

Utilization

- Use of services: Provision and utilization of services by a group of individuals identified by enrollment in a health plan or through use of clinical services[39]

3. Level of Reporting

This measure is intended to be used at a systems level, such as at the Medicaid program or dental plan level.

4. Data Source

Administrative claims and enrollment data; single year. When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

5. Critical Data Elements

Enrollment Database	Claims Database
• Member ID • Date of birth • Enrollment start and end dates	• Member ID • Date of service • CDT codes • National Uniform Claim Committee health care provider taxonomy codes

[39] National Quality Measures Clearinghouse. N.d. *Guidelines and Measures* [webpage]. www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx

Indicator Domain: UTILIZATION

Indicator C.3. Preventive Services for Children at Elevated Caries Risk, Dental Services

Source: American Dental Association on behalf of the Dental Quality Alliance (DQA). Please use the DQA website to access the specification details.

1. Description

Percentage of enrolled children who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants within the reporting year

- **Numerator:** Unduplicated number of children at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants as a dental service
- **Denominator:** Unduplicated number of enrolled children at "elevated" risk (i.e., "moderate" or "high")

2. Framework Domain

Utilization

- Use of services: Provision and utilization of services by a group of individuals identified by enrollment in a health plan or through use of clinical services[40]

3. Level of Reporting

This measure is intended to be used at a systems level, (e.g., Medicaid program level, dental plan level).

4. Data Source

Administrative claims and enrollment data; single year (prior 3 years needed for risk determination). When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

5. Critical Data Elements

Enrollment Database	Claims Database
• Member ID • Date of birth • Enrollment start and end dates	• Member ID • Date of service • CDT codes • National Uniform Claim Committee health care provider taxonomy codes

[40] National Quality Measures Clearinghouse. N.d. *Guidelines and Measures.* [webpage]. www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx

Indicator Domain: PROCESS

Indicator C.4. Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services (NQF #2528)

Source: American Dental Association on behalf of the Dental Quality Alliance (DQA). Please use the DQA website to access the specification details.

1. Description

Percentage of enrolled children aged 1–21 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year

- **Numerator:** Unduplicated number of children at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as a dental service
- **Denominator:** Unduplicated number of enrolled children aged 1–21 years at "elevated" risk (i.e. "moderate" or "high")

2. Framework Domain

Process

- Evidence-based care: Oral health care is provided using the judicious integration of systematic assessments of clinically relevant scientific evidence (evidence-based guidelines), relating to the person's oral and medical condition and history, with the oral health care provider's clinical expertise and the person's treatment needs and preferences.

3. Level of Reporting

This measure is intended to be used at a systems level (e.g., Medicaid program level, dental plan level).

4. Data Source

Administrative claims and enrollment data; single year (prior 3 years needed for risk determination). When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

5. Critical Data Elements

Enrollment Database	Claims Database
• Member ID • Date of birth • Enrollment start and end dates	• Member ID • Date of service • CDT codes • National Uniform Claim Committee health care provider taxonomy codes

Indicator Domain: PROCESS

Indicator C.5. Prevention: Topical Fluoride for Children at Elevated Caries Risk, Oral Health Services

Source: American Dental Association on behalf of the Dental Quality Alliance (DQA). Please use the DQA website to access the specification details.

1. Description

Percentage of enrolled children aged 1–21 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as oral health services within the reporting year

- **Numerator:** Unduplicated number of children at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as oral health services
- **Denominator:** Unduplicated number of enrolled children aged 1–21 years at "elevated" risk (i.e. "moderate" or "high")

2. Framework Domain

Process

Evidence-based care: Oral health care is provided using the judicious integration of systematic assessments of clinically relevant scientific evidence (evidence-based guidelines), relating to the person's oral and medical condition and history, with the oral health provider's clinical expertise and the person's treatment needs and preferences.

3. Level of Reporting

This measure is intended to be used at a systems level (e.g., Medicaid program level, dental plan level).

4. Data Source

Administrative claims and enrollment data; single year (prior 3 years needed for risk determination). When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

5. Critical Data Elements

Enrollment Database	Claims Database
• Member ID • Date of birth • Enrollment start and end dates	• Member ID • Date of service • CDT codes • CPT codes (selected states) • National Uniform Claim Committee health care provider taxonomy codes

Indicator Domain: PROCESS

Indicator C.6. Prevention: Sealants for 6–9 Year-Old Children at Elevated Risk, Dental Services

Source: American Dental Association on behalf of the Dental Quality Alliance (DQA). Please use the DQA website to access the specification details.

1. Description

Percentage of enrolled children in the age category of **6–9** years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent **first** molar tooth within the reporting year

- **Numerator:** Unduplicated number of all enrolled children age **6–9** years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent **first** molar tooth as a dental service
- **Denominator:** Unduplicated number of enrolled children age 6–9 years at "elevated" risk (i.e., "moderate" or "high")

2. Framework Domain

Process

- Evidence-based care: Oral health care is provided using the judicious integration of systematic assessments of clinically relevant scientific evidence (evidence-based guidelines), relating to the person's oral and medical condition and history, with the oral health provider's clinical expertise and the person's treatment needs and preferences

3. Level of Reporting

This measure is intended to be used at a systems level, (e.g., Medicaid program level, dental plan level).

4. Data Source

Administrative claims and enrollment data; single year (prior 3 years needed for risk determination). When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

5. Critical Data Elements

Enrollment Database	Claims Database
• Member ID • Date of birth • Enrollment start and end dates	• Member ID • Date of service • CDT codes • Tooth number • National Uniform Claim Committee health care provider taxonomy codes

Indicator Domain: PROCESS

Indicator C.7. Prevention: Sealants for 10–14 Year-Old Children at Elevated Risk, Dental Services

Source: American Dental Association on behalf of the Dental Quality Alliance. Please use the DQA website to access the specification details.

1. Description

Percentage of enrolled children in the age category of **10–14** years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent **second** molar tooth within the reporting year

- **Numerator:** Unduplicated number of enrolled children age **10–14** years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent **second** molar tooth as a dental service
- **Denominator:** Unduplicated number of enrolled children age **10–14** years at "elevated" risk (i.e., "moderate" or "high")

2. Framework Domain

Process

- Evidence-based care: Oral health care is provided using the judicious integration of systematic assessments of clinically relevant scientific evidence (evidence-based guidelines), relating to the person's oral and medical condition and history, with the oral health provider's clinical expertise and the person's treatment needs and preferences.

3. Level of Reporting

This measure is intended to be used at a systems level, (e.g., Medicaid program level, dental plan level).

4. Data Source

Administrative claims and enrollment data; single year (prior 3 years needed for risk determination). When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims).

5. Critical Data Elements

Enrollment Database	Claims Database
• Member ID • Date of birth • Enrollment start and end dates	• Member ID • Date of service • CDT codes • Tooth number • National Uniform Claim Committee health care provider taxonomy codes

Indicator Domain: OUTCOME

Indicator C.8. Percentage of Kindergarten Children with Dental Caries Experience (Treated or Untreated Tooth Decay)

Source: Basic Screening Survey (BSS), Association of State and Territorial Dental Directors (ASTDD) (www.astdd.org/basic-screening-survey-tool)

1. Description

Percentage of kindergarten children with dental caries experience (treated or untreated tooth decay)

- **Numerator:** Number of kindergarten children with treated or untreated tooth decay
- **Denominator:** Number of kindergarten children screened

2. Framework Domain

Outcome

- Health status: The health state of a person or change in health state resulting from health care

3. Level of Reporting

This is a state-level, population-based surveillance measure of the burden of oral disease among kindergarten children.

4. Data Source

Clinical screening examinations using the BSS tool developed by ASTDD.

5. Data Elements

Critical Data Elements	
Kindergarten BSS	
Children screened	
Dental caries experience	
Available Stratification Elements	
Race/ethnicity	Option 1 Non-Hispanic White Hispanic and Non-Hispanic other Unknown/missing Option 2 Hispanic Non-Hispanic White Non-Hispanic Black

	Non-Hispanic other Unknown/missing

6. Measure Guidance

- **Data-collection year.** Indicate the school year of the most recent kindergarten BSS. Also indicate when the next survey is planned.
- **Adjustment for sampling methodology.** Data should be adjusted for the complex sampling scheme, following guidance provided by ASTDD.[41]

7. Measure Calculation: Detailed Specification

A. Denominator

Step 1: Identify the number of children screened in the state during the most recent kindergarten BSS.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Children screened in the state during the most recent kindergarten BSS

B. Numerator

Step 1: Determine the subset of the denominator (number of children screened) who were identified as having any caries experience in the **primary or permanent** dentition (treated decay or untreated decay):

a. If treated decay=YES, OR
b. If untreated decay=YES, then include in numerator; STOP processing.
c. If a OR b is not met (i.e., if treated decay=no AND untreated decay=no), then do not include the child in the numerator

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Children screened in the state during the most recent kindergarten BSS who have caries experience

C. Denominator Exclusions/Exceptions

Exclude children from the denominator with:

a. Missing variables for **both** treated decay and untreated decay
b. Treated decay=NO **and** untreated decay=missing
c. Treated decay=missing **and** untreated decay=NO

D. Reporting Stratifications

a. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, Non-Hispanic multiple race, unknown/missing)

Note: If data limitations necessitate, race categories can be collapsed as: Non-Hispanic White, Hispanic and Non-Hispanic other race, and unknown/missing

[41] Association of State and Territorial Dental Directors. 2017. *Guidance on How to Analyze Data from a School-Based Oral Health Survey*. www.astdd.org/docs/school-survey-analysis-guidance-july-2017.pdf

E. Measure Score

Report:

a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted
e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Whether positive or passive consent is used and the response rate

8. Limitations

BSS tools were developed by ASTDD to help state and local public health agencies monitor the burden of oral disease at a level consistent with *Healthy People* objectives. BSS tools were not designed to measure small changes in disease levels and are probably not appropriate for use in oral health research.[42]

The BSS is typically conducted at a recommended interval of every 5 years within a state. Consequently, this outcome indicator will not be updated annually.

If a state uses positive consent, the information is representative only of children whose families returned a consent form. ASTDD encourages states to use passive (opt-out) consent.

9. Additional Notes

Additional information on the BSS is available at www.astdd.org/basic-screening-survey-tool.

[42] Association of State and Territorial Dental Directors. 2017. *The Basic Screening Survey: A Tool for Oral Health Surveillance Not Research.* Reno, NV: Association of State and Territorial Dental Directors. www.astdd.org/docs/bss-surveillance-not-research-july-2017.pdf

Indicator Domain: OUTCOME

Indicator C.9. Percentage of Third-Grade Children with Dental Caries Experience (Treated or Untreated Tooth Decay)

Source: Basic Screening Survey (BSS), Association of State and Territorial Dental Directors (ASTDD) (www.astdd.org/basic-screening-survey-tool)

1. Description

Percentage of third-grade children with dental caries experience (treated or untreated tooth decay)

- **Numerator:** Number of third-grade children with treated or untreated tooth decay
- **Denominator:** Number of third-grade children screened

2. Framework Domain

Outcome

- Health status: The health state of a person or change in health state resulting from health care

3. Level of Reporting

This is a state-level, population-based surveillance measure of the burden of oral disease among third-grade children.

4. Data Source

Clinical screening examinations using the BSS tool developed by ASTDD.

5. Data Elements

Critical Data Elements	
Third-grade BSS	
Children screened	
Dental caries experience	
Available Stratification Elements	
Race/ethnicity	Option 1 Non-Hispanic White Hispanic and Non-Hispanic other Unknown/missing Option 2 Hispanic Non-Hispanic White Non-Hispanic Black

	Non-Hispanic other Unknown/missing

6. Measure Guidance

- **Data-collection year.** Indicate the school year of the most recent third-grade BSS. Also indicate when the next survey is planned.
- **Adjustment for sampling methodology.** The data should be adjusted for the complex sampling scheme, following guidance provided by ASTDD.[43]

7. Measure Calculation: Detailed Specification

A. Denominator

Step 1: Identify the number of children screened in the state during the most recent third-grade BSS.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Children screened in the state during the most recent third-grade BSS

B. Numerator

Step 1: Determine the subset of the denominator (number of children screened) who were identified as having any caries experience in the **primary or permanent** dentition (treated decay or untreated decay):

a. If treated decay=YES, OR
b. If untreated decay=YES, then include in numerator; STOP processing.
c. If a OR b is not met (i.e., if treated decay=no AND untreated decay=no), then do not include the child in the numerator

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Children screened in the state during the most recent third-grade BSS who have caries experience

C. Denominator Exclusions/Exceptions

Exclude children from the denominator with:

a. Missing variables for **both** treated decay and untreated decay;
b. Treated decay=NO **and** untreated decay=missing
c. Treated decay=missing **and** untreated decay=NO

D. Reporting Stratifications

a. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, Non-Hispanic multiple race, unknown/missing)

Note: If data limitations necessitate, race categories can be collapsed as: Non-Hispanic White, Hispanic and Non-Hispanic other race, and unknown/missing

[43]Association of State and Territorial Dental Directors. 2017. *Guidance on How to Analyze Data from a School-Based Oral Health Survey*. www.astdd.org/docs/school-survey-analysis-guidance-july-2017.pdf

E. Measure Score

Report:

a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted
e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Whether positive or passive consent is used and the response rate

8. Limitations

BSS tools were developed by ASTDD to help state and local public health agencies monitor the burden of oral disease at a level consistent with *Healthy People* objectives. BSS tools were not designed to measure small changes in disease levels and are probably not appropriate for use in oral health research.[44]

The BSS is typically conducted at a recommended interval of every 5 years within a state. Consequently, this outcome indicator will not be updated annually.

If a state uses positive consent, the information is representative only of children whose families returned a consent form. ASTDD encourages states to use passive (opt-out) consent.

9. Additional Notes

Additional information on the BSS is available at www.astdd.org/basic-screening-survey-tool.

[44] Association of State and Territorial Dental Directors. 2017. *The Basic Screening Survey: A Tool for Oral Health Surveillance Not Research.* Reno, NV: Association of State and Territorial Dental Directors. www.astdd.org/docs/bss-surveillance-not-research-july-2017.pdf

Indicator Domain: OUTCOME

Indicator C.10. Percentage of Kindergarten Children with Urgent Dental Treatment Needs

Source: Basic Screening Survey (BSS), Association of State and Territorial Dental Directors (ASTDD) (www.astdd.org/basic-screening-survey-tool)

1. Description

Percentage of kindergarten children with urgent dental treatment needs

- **Numerator:** Number of kindergarten children needing urgent dental care
- **Denominator:** Number of kindergarten children screened

2. Framework Domain

Outcome

- Health status: The health state of a person or change in health state resulting from health care

3. Level of Reporting

This is a state-level, population-based surveillance measure of the burden of oral disease among kindergarten children.

4. Data Source

Clinical screening examinations using the BSS tool developed by ASTDD.

5. Data Elements

Critical Data Elements	
Kindergarten BSS	
Children screened	
Needs urgent dental care	
Available Stratification Elements	
Race/ethnicity	Option 1 Non-Hispanic White Hispanic and Non-Hispanic other Unknown/missing Option 2 Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic other Unknown/missing

6. Measure Guidance

- **Data-collection year.** Indicate the school year of the most recent kindergarten BSS. Also indicate when the next survey is planned.
- **Adjustment for sampling methodology.** The data should be adjusted for the complex sampling scheme, following guidance provided by ASTDD.[45]

7. Measure Calculation: Detailed Specification

A. Denominator

Step 1: Identify the number of children screened in the state during the most recent kindergarten BSS.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Children screened in the state during the most recent kindergarten BSS

B. Numerator

Step 1: Determine the subset of the denominator (number of children screened) who were identified as needing urgent dental care.

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Children screened in the state during the most recent kindergarten BSS who needed urgent dental care

C. Denominator Exclusions/Exceptions

Exclude children with missing variable for needs urgent dental care.

D. Reporting Stratifications

a. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, Non-Hispanic Black multiple race, unknown/missing)

Note: If data limitations necessitate, race categories can be collapsed as: Non-Hispanic White, Hispanic and Non-Hispanic other race, and unknown/missing)

E. Measure Score

Report:

a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted
e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Whether positive or passive consent is used and the response rate

[45]Association of State and Territorial Dental Directors. 2017. *Guidance on How to Analyze Data from a School-Based Oral Health Survey*. www.astdd.org/docs/school-survey-analysis-guidance-july-2017.pdf

8. Limitations

BSS tools were developed by ASTDD to help state and local public health agencies monitor the burden of oral disease at a level consistent with *Healthy People* objectives. BSS tools were not designed to measure small changes in disease levels and are probably not appropriate for use in oral health research.[46]

The BSS is typically conducted at a recommended interval of every 5 years within a state. Consequently, this outcome indicator will not be updated annually.

If a state uses positive consent, the information is representative only of children whose families returned a consent form. ASTDD encourages states to use passive (opt-out) consent.

9. Additional Notes

Additional information on the BSS is available at http://www.astdd.org/basic-screening-survey-tool.

[46] Association of State and Territorial Dental Directors. 2017. *The Basic Screening Survey: A Tool for Oral Health Surveillance Not Research.* Reno, NV: Association of State and Territorial Dental Directors. www.astdd.org/docs/bss-surveillance-not-research-july-2017.pdf.

Indicator Domain: OUTCOME

Indicator C.11. Percentage of Third-Grade Children with Urgent Dental Treatment Needs

Source: Basic Screening Survey (BSS), Association of State and Territorial Dental Directors (ASTDD) (www.astdd.org/basic-screening-survey-tool)

1. Description

Percentage of third-grade children with urgent dental treatment needs

- **Numerator:** Number of third-grade children needing urgent dental care
- **Denominator:** Number of third-grade children screened

2. Framework Domain

Outcome

- Health status: The health state of a person or change in health state resulting from health care

3. Level of Reporting

This is a state-level, population-based surveillance measure of the burden of oral disease among third-grade children.

4. Data Source

Clinical screening examinations using the BSS tool developed by ASTDD.

5. Data Elements

Critical Data Elements	
Third-grade BSS	
Children screened	
Needs urgent dental care	
Available Stratification Elements	
Race/ethnicity	Option 1 Non-Hispanic White Hispanic and Non-Hispanic other Unknown/missing Option 2 Hispanic Non-Hispanic White Non-Hispanic Black Non-Hispanic other Unknown/missing

6. Measure Guidance

- **Data-collection year.** Indicate the school year of the most recent third-grade BSS. Also indicate when the next survey is planned.
- **Adjustment for sampling methodology.** Data should be adjusted for the complex sampling scheme, following guidance provided by ASTDD.[47]

7. Measure Calculation: Detailed Specification

A. Denominator

Step 1: Identify the number of children screened in the state during the most recent third-grade BSS.

YOU NOW HAVE THE DENOMINATOR (DEN) COUNT: Children screened in the state during the most recent third-grade BSS

B. Numerator

Step 1: Determine the subset of the denominator (number of children screened) who were identified as needing urgent dental care.

YOU NOW HAVE THE NUMERATOR (NUM) COUNT: Children screened in the state during the most recent third-grade BSS who needed urgent dental care

C. Denominator Exclusions/Exceptions

Exclude children with missing variable for needs urgent dental care.

D. Reporting Stratifications

a. Race/ethnicity (Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic other race, Non-Hispanic multiple race, unknown/missing)

Note: If data limitations necessitate, race categories can be collapsed as: Non-Hispanic White, Hispanic and Non-Hispanic other race, and unknown/missing)

E. Measure Score

Report:

a. Number in denominator, unweighted sample count
b. Number in numerator, unweighted sample count
c. Number in denominator, weighted
d. Number in numerator, weighted
e. Measure score (NUM/DEN), weighted, with 95% confidence interval
f. Number of individuals excluded
g. Measure score, weighted, stratified by [reporting stratification] with 95% confidence intervals and unweighted denominator count
h. Whether positive or passive consent is used and the response rate

[47]Association of State and Territorial Dental Directors. 2017. *Guidance on How to Analyze Data from a School-Based Oral Health Survey*. www.astdd.org/docs/school-survey-analysis-guidance-july-2017.pdf

8. Limitations

BSS tools were developed by ASTDD to assist state and local public health agencies monitor the burden of oral disease at a level consistent with *Healthy People* objectives. BSS tools were not designed to measure small changes in disease levels and are probably not appropriate for use in oral health research.[48]

The BSS is typically conducted at a recommended interval of every 5 years within a state. Consequently, this outcome indicator will not be updated annually.

If a state uses positive consent, the information is representative only of children whose families returned a consent form. ASTDD encourages states to use passive (opt-out) consent.

9. Additional Notes

Additional information on the BSS is available at www.astdd.org/basic-screening-survey-tool.

[48] Association of State and Territorial Dental Directors. 2017. *The Basic Screening Survey: A Tool for Oral Health Surveillance Not Research.* Reno, NV: Association of State and Territorial Dental Directors. www.astdd.org/docs/bss-surveillance-not-research-july-2017.pdf

Appendix 1: Feasibility Assessment Tool

Background Information

Name of person completing assessment: _____

Title/position: _____

Agency/department: _____

Current Improvement Activities

1. Has your state/agency developed oral-health-improvement goals for the following populations? If yes, please check all that apply.

   ❒ Women of child-bearing age
   ❒ Pregnant women
   ❒ Children
   ❒ Children with special health care needs

2. Does your agency report on or use any oral health quality indicators (sometimes referred to as measures)?

   ❒ Yes
   ❒ No

   If yes:

   a. Please list the measures that your agency reports on or uses in the table below, indicating whether your agency calculates measure scores using data it has access to or if the measures are obtained from another source.

Measure Name	**Measure Source/ Steward (if not sure, list where you found the measure)**	**Measure Data Source (e.g., claims, survey, electronic health record)**	**Measure Population**	**Calculated by Your Agency/ Obtained Elsewhere**
Example: Topical fluoride for children at elevated risk for dental caries	*Dental Quality Alliance*	*Medicaid claims*	*Children age 1 through 20 years*	*Obtained from state Medicaid agency*

   b. Review current measurement reports.

Set of MCH Indicators: Women of Child-Bearing Age and Pregnant Women

Summary

Access

- Percentage of pregnant women reporting difficulty getting dental care (Data source: PRAMS)
- Percentage of pregnant women who had insurance to cover dental care during pregnancy (Data source: PRAMS)

Utilization

- Percentage of pregnant women who reported having their teeth cleaned by a dentist or dental hygienist during pregnancy (Data source: PRAMS)
- Percentage of women of child-bearing age (18–44 years) who report having a visit to a dentist or dental clinic in the past year (Data source: BRFSS)

Outcome

- Percentage of pregnant women reporting that they needed to see a dentist for a problem during pregnancy (Data source: PRAMS)

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

3. What agency within your state administers the PRAMS survey?

4. Please indicate whether the following questions were included in your state's 2018 PRAMS survey. (If information is not available for the 2018 survey, indicate the most recent year for which you are responding.)

PRAMS Phase 8 Question	**Included on your state's 2018 PRAMS survey?**
17. During *your most recent* pregnancy, did you have your teeth cleaned by a dentist or dental hygienist? • No • Yes	❒ Yes ❒ No
Y6. Did any of the following things make it hard for you to go to a dentist or dental clinic about the problem you had during *your most recent* pregnancy? For each item, check No if it was not something that made it hard for you or Yes if it was. • I could not find a dentist or dental clinic that would take pregnant patients • I could not find a dentist or dental clinic that would take Medicaid patients	❒ Yes ❒ No

PRAMS Phase 8 Question	Included on your state's 2018 PRAMS survey?
• I did not think it was safe to go to the dentist during pregnancy • I could not afford to go to the dentist or dental clinic	
Y7. This question is about the care of your teeth *during your most recent pregnancy*. For each item, check No if it is not true or does not apply to you or Yes if it is true. o I knew it was important to care for my teeth and gums during my pregnancy o A dental or other health care worker talked with me about how to care for my teeth and gums o I had my teeth cleaned by a dentist or dental hygienist o I had insurance to cover dental care during my pregnancy o I needed to see a dentist for a **problem** o I went to a dentist or dental clinic about a **problem**	❒ Yes ❒ No

5. Does your Title V MCH program have access to your state's PRAMS data?

❒ Yes, direct access—can pull data directly from PRAMS database

❒ Yes, indirect access—access granted through a memorandum of understanding (MOU) or collaborative agreement

List agency providing data:

❒ No current access to these data

6. a. If your Title V MCH program does not have access to your state's PRAMS data, please describe the agreements and processes that need to be put in place to obtain data or summary reports. Please also describe potential barriers.

b. Please rate how difficult you believe it will be to gain access to your state's PRAMS data.

❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

7. a. Please describe the processes required to add PRAMS questions (the questions in Item #4 above, if not already included) to your state's PRAMS survey for implementation in 2020. Please also describe potential barriers.

b. Please rate how difficult you believe it will be to add questions to your state's PRAMS survey for implementation in 2020.

❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

8. a. Does the agency that administers your state's Title V MCH program have personnel who could conduct data analyses using PRAMS data to calculate oral health quality indicator scores?

❒ Yes ❒ No ❒ Unsure

b. If no, please indicate how difficult you believe it will be to establish an agreement with the agency that administers PRAMS surveys to have the oral health indicator scores calculated.

❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

9. What agency within your state administers the BRFSS survey?

10. Please indicate whether the following question was included in your state's 2018 BRFSS survey. (If information is not available for the 2018 survey, indicate the most recent year for which you are responding.)

BRFSS Question	**Included on your state's 2018 BRFSS survey?**
C07.01Including all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists, how long has it been since you last visited a dentist or a dental clinic for any reason? [Response options only read if necessary.] • Within the past year (any time less than 12 months ago) • Within the past 2 years (1 year but less than 2 years ago) • Within the past 5 years (2 years but less than 5 years ago) • 5 or more years ago • Don't know/not sure • Never	❒ Yes ❒ No

11. Does your Title V MCH program have access to your state's BRFSS data?

❒ Yes, direct access—can pull data directly from BRFSS database ❒ Yes, indirect access—access granted through an MOU or collaborative agreement ❒ No current access to these data

List agency providing data:

12. a. If your Title V MCH program does <u>not</u> have access to your state's BRFSS data, please describe the agreements and processes that need to be in place to obtain data or summary reports. Please also describe potential barriers.

    b. Please rate how difficult you believe it will be to gain access to your state's BRFSS data.

    ❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

13. a. Does the agency that administers your state's Title V MCH program have personnel who could conduct data analyses using the BRFSS data to generate the quality indicator score?

    Note: The BRFSS indicator requires stratification by gender and age to report on women age 18–44 years.

    ❒ Yes ❒ No ❒ Unsure

    b. If no, please indicate how difficult you believe it will be to establish an agreement with the agency that administers the BRFSS to have the indicator score calculated.

    ❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Set of Indicators: Children

Summary

<u>Access</u>

- Dentists who actively participate in Medicaid per 1,000 EPSDT eligible enrolled children (Data source: Medicaid enrollment and claims)

<u>Utilization</u>

- Percentage of children who had a dental visit in the last 12 months (Data source: Medicaid enrollment and claims)
- Percentage of children at elevated risk receiving preventive dental services (Data source: Medicaid enrollment and claims)

<u>Process</u>

- Percentage of children at elevated risk receiving at least two topical fluoride applications as a dental service (Data source: Medicaid enrollment and claims)

- Percentage of children at elevated risk receiving at least two topical fluoride applications as an oral health service (Data source: Medicaid enrollment and claims)
- Percentage of children age 6–9 years at elevated risk who receive sealants in their permanent first molars (Data source: Medicaid enrollment and claims)
- Percentage of children age 10–14 years at elevated risk who receive sealants in their permanent second molars (Data source: Medicaid enrollment and claims)

Outcome

- Percentage of kindergarten children with dental caries experience (treated or untreated tooth decay) (Data source: Basic Screening Survey [BSS])
- Percentage of third-grade children with dental caries experience (treated or untreated tooth decay) (Data source: BSS)
- Percentage of kindergarten children with urgent dental treatment needs (Data source: BSS)
- Percentage of third-grade children with urgent dental treatment needs (Data source: BSS)

Data Source: Medicaid Enrollment and Claims Data

14. What agency within your state administers the Medicaid program?

15. Does your Title V MCH program have access to your state's Medicaid enrollment and claims data?

❒ Yes, direct access—can pull data directly from Medicaid databases

❒ Yes, indirect access—access granted through an MOU or collaborative agreement

List agency providing data:

❒ No current access to these data

16. a. If your Title V MCH program does not have access to your state's Medicaid enrollment and claims data, please describe the agreements and processes that need to be in place to obtain data or summary reports. Please also describe potential barriers.

b. Please rate how difficult you believe it will be to gain access to your state's Medicaid data.

❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

17. a. Does the agency that administers your state's Title V MCH program have personnel who could conduct data analyses using Medicaid enrollment and claims data to calculate quality indicator scores?

❒ Yes ❒ No ❒ Unsure

b. If no, please indicate how difficult you believe it will be to establish an agreement with the agency that administers the Medicaid program to have the indicator scores calculated.

❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Data Source: State Oral Health Screening Survey/BSS

18. What agency within your state administers oral health screening surveys/BSS surveys (clinical screening of teeth and determination of oral health status)?

19. Please indicate which populations are screened and the years in which screening occurred.

Population	2018	2017	2016	2015	2014	2013
Early Head Start	❒	❒	❒	❒	❒	❒
Head Start	❒	❒	❒	❒	❒	❒
Kindergarten	❒	❒	❒	❒	❒	❒
Third grade	❒	❒	❒	❒	❒	❒
Women of reproductive age/Pregnant women	❒	❒	❒	❒	❒	❒
Other (list):	❒	❒	❒	❒	❒	❒

20. Does your Title V MCH program have access to your state's oral health/BSS surveys?

❒ Yes, direct access—can pull data directly from screening databases

❒ Yes, indirect access—access granted through an MOU or collaborative agreement

List agency providing data:

❒ No current access to these data

21. a. If your Title V MCH program does <u>not</u> have access to your state's oral health screening/BSS data, please describe the agreements and processes that need to be in place to obtain data or summary reports. Please also describe potential barriers.

b. Please rate how difficult you believe it will be to gain access to your state's oral health screening/BSS data:

❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

22. a. Does the agency that administers your state's Title V MCH program have personnel who could conduct data analyses using oral health screening/BSS data to generate quality indicator scores?

❒ Yes ❒ No ❒ Unsure

b. If no, please indicate how difficult you believe it will be to establish an agreement with the agency that administers the oral health screening/BSS program to have the measure scores calculated.

❒ Not difficult ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Other Data Sources

23. Does your state have any registries or other integrated data systems that include oral health data (e.g., registries for oral cancer or cleft lip and palate)? If yes, please describe.

24. Do any agencies within your state have the ability to report data from electronic health records for any Title V subpopulations (e.g., pregnant women, children)? If yes, please describe data availability and for which subpopulations.

25. Please describe any other relevant oral health data within your state that could be used for performance assessment and quality improvement.

Additional comments: